Emergency Housing and Assistance Program (EHAP)
Funding Round 14
Fiscal Year 2006-2007

Statewide
Application Package

September 22, 2006

State of California
Department of Housing and
Community Development

EHAP 14 STATE APPLICATION CHECKLIST AND CERTIFICATION

General Instructions: Please read the EHAP Regulations and the Budget Act of 2006 carefully. Prepare a separate Operating Facility application for each site (or project, if on scattered sites; see EHAP Regulations, Definitions, for definition of "site"). Use this index/checklist to ensure you organize and include all necessary information. Incomplete or missing information may cause your application to be rejected, or receive lower scores. Please type or print neatly.

Submit two complete sets of the application, one with original signatures and one copy. Mark the applications “Original” and “Copy.”

1. Please submit the original in a white three-ring binder. Display your agency name and the county for which you are applying on the binder spine. The copy should be bound together with a rubberband or clip; a binder is not necessary.

2. Use numbered, tabbed dividers to divide the binder into three sections: I, II and III. Please tab all exhibits and attachments. It is not necessary to insert dividers into the copy of the application but follow the same order as the original application.

3. In each section, set up dividers with lettered tabs to correspond to the outline on page 3. Place the required documents behind their corresponding tabs.

4. For items that are not applicable to your application, place sheets saying “Not Applicable” behind the tabs corresponding to those items.

5. If your organization is applying for an Emergency Shelter grant and a Transitional Housing grant for the same site, separate applications must be submitted.

APPLICANT NAME:_____

COUNTY:_____

AMOUNT OF THIS GRANT REQUEST: $ _____

TYPE OF GRANT: (check one) _____ Operating Facility _____ Operating Facility with capital development-type activities of $20,000 or less

TYPE OF SHELTER: (check one only)

EMERGENCY SHELTER _____

TRANSITIONAL HOUSING _____

NUMBER OF ORIGINAL EHAP 14 APPLICATIONS SUBMITTED: _____

If your organization has submitted more than one application, note the additional information here.

County _____ **Grant Amount Requested $**_____

All applicants must complete and submit the Checklist and Certification, Section I and Section II. Applicants applying for any amount of capital development-type activities (Acquisition, New Construction, Rehabilitation, Conversion, or Equipment) must also submit Section III. (Applications missing mandatory items will be considered ineligible for rating and ranking.)

[ ] STATE APPLICATION CHECKLIST AND CERTIFICATION (Pages 1 – 3)

SECTION I: APPLICATION FORMS AND RATING QUESTIONS (ALL APPLICANTS)

[ ] A. General Applicant Information
[ ] B. Statement of Applicant Eligibility
[ ] C. Rating and Ranking Criteria
[ ] D. Payee Data Record (form provided in application)

Exhibits A – J

[ ] Exhibit A – Organization Chart
[ ] Exhibit B – EHAP Project Key Staffing (form provided)
[ ] Exhibit B-1 etc. – Duty Statements
[ ] Exhibit C – Annual Financial Statement
[ ] Exhibit D - Audit Report
[ ] Exhibit E – Financial Manager's Resume
[ ] Exhibit F-1 etc. – Support Services Letters
[ ] Exhibit G-1, G-2, G-3 – Community Needs Plan pages
[ ] Exhibit H – Client Placement Documentation
[ ] Exhibit I - Five Year History of Funding Sources
[ ] Exhibit J-1 - Income and Expense Statement (form provided)
[ ] Exhibit J-2 - Summary Budget and Fund Request (form provided)
[ ] Exhibit J-3 - Detail of Operations Activities (form provided)

SECTION II: REQUIRED ATTACHMENTS (ALL APPLICANTS)

[ ] A. Authorizing resolution of governing board using Sample Resolution language and format
[ ] B. Policies and Conditions of Stay (e.g., intake procedures, house rules)
[ ] C. Copy of IRS Form 501(c)(3), or local government authorizing resolution
[ ] D. Copy of Articles of Incorporation and any amendments
[ ] E. Evidence of Site Control (e.g., Lease/Rental agreement, Grant Deed. Documentation must include site address and cover grant period.)

SECTION III: ADDITIONAL GRANT PROPOSAL INFORMATION FOR OPERATING FACILITIES GRANT APPLICANTS WITH CAPITAL DEVELOPMENT-TYPE ACTIVITIES (i.e. Acquisition, New Construction, Rehabilitation, Conversion, or Equipment)

[ ] A. Site Description
[ ] B. Capital Development Project Activities Schedule
[ ] C. Detailed Cost Estimates

CERTIFICATION OF APPLICATION INFORMATION

I am authorized to apply on behalf of _____ and attest that all information contained in this application is accurate and complete to the best of my knowledge. All information contained in this application is acknowledged to be public information. I authorize the Department of Housing and Community Development to contact any or all of the parties listed in this proposal.

_____

Authorized Signature for Applicant (authorized by resolution)

_____ _____

Printed Name Title

_____

Date

INSTRUCTIONS FOR COMPLETING GENERAL APPLICANT INFORMATION

Please follow these step-by-step instructions for completing the "General Applicant Information" on pages 6 and 7. It is important for reviewing purposes that the "General Applicant Information" section be completed correctly.

Applicant Name:	Provide the name of the organization that will be administering the funds. The name must be the same as stated on the Resolution and the Articles of Incorporation and any amendments (submitted as in Section II). If it is different from one or both of these documents, an explanation must be provided on a separate sheet of paper and attached immediately behind the first page of the Application Summary Form. **Do not include DBA's (Doing Business As).**
County allocation:	Provide the name of the county where the funds are to be allocated. This may be different from the county where the shelter/program is actually located/operated.
Type of Applicant:	Indicate whether the applicant is a Nonprofit or Government Agency. Community Action Agencies will be considered a nonprofit unless the resolution is from the Board of Supervisors.
Total Grant Amount:	Provide the total grant amount you are requesting in this application.
City:	Provide the name of the city(ies) where the shelter/program is located/operated. This is not where the administrative office is located unless it is located onsite at the shelter/program.
County:	Provide the name of the county where the shelter/program is located/operated. This may or may not be the same as the "County" provided above. This is not where the administrative office is located unless it is located onsite at the shelter/program.
Street Address or P.O. Box City and Zip Code:	Provide the address for the administrative office.
Authorized Signatory Representative:	Provide the name and title of the person that is authorized to sign the Application and the Standard Agreement as stated in the Resolution.
Telephone Number:	Provide the phone number for the administrative office.
Fax Number:	Provide the fax number for the administrative office.
Email Address:	Provide the email address for the Authorized Signatory Representative.
Contact Person:	Provide the name and title of the person to be contacted regarding the grant.
Telephone Number:	Provide the phone number for the person to be contacted regarding the grant. Include an extension number if available.
Fax Number:	Provide the fax number for the person to be contacted regarding the grant.
Email Address:	Provide the email address for the person to be contacted regarding the grant.
Amounts Requested For Each Major Funding Category:	Indicate the dollar amounts for each major funding category that you are applying for. Administration cannot exceed 5% of the total grant amount. The total must equal the total grant amount indicated above.

INSTRUCTIONS FOR COMPLETING GENERAL APPLICANT INFORMATION (Cont'd.)

Primary Target Population: Check only one box for the primary target population that will be served by this project. An agency's "primary target population" is the target population with the largest number of clients the agency served compared to any other target population(s) served. If the group isn't listed, please check "Other" and briefly identify the primary target population on the line provided.

Project/Shelter Provide physical address(s) of actual shelter location(s). Do not use post office box.

Project/Shelter Information Provide the name, address, city, zip code (plus your 4 digit number) and county for each program/site. If this is a multi-organization application, (collaborative application), provide the organization name, address, city, zip code and county for each program/site.

You must provide the address where the program/site is located, **even for confidential sites.** If the address is **confidential**, indicate by checking the "Confidential" box. This confidential address **will not** be entered into a database.

If you do not know the four (4) digits that follow your zipcode, please reference it at http://zip4.usps.com/zip4/citytown_zip.jsp. This 4 digit number is crucial for your project site address.

Requested Amount: Indicate the portion of the grant amount requested for this site.

Average Number of Persons Served Daily: Please utilize the following formula to determine this count.

1. Take your existing daily count of persons served and project it over the next twelve months (duplicate counts of the same persons served on different days is acceptable).
2. Divide this number by 12 to obtain monthly count.
3. Divide the product by 30 to obtain average number of persons served daily.
4. Round this product to the nearest whole number.

Sample: 24,000 persons to be served within the next twelve (12) months / 12 = 2000
2000 / 30 = 66.66 (rounded to 67)

Voucher and Residential Rental Assistance Programs must also report Average # of Persons Served Daily. To determine your daily count of persons served, calculate the number of persons served annually and divide that number by 360.

Maximum Bed Capacity Indicate the shelter's Maximum Bed Capacity.

Semi-Annual Report For reporting milestones on the Semi-Annual Report (SAR), indicate the estimated number of unduplicated clients you will serve over the fourteen month (14) grant period, at the site for which EHAP funds are requested. This number becomes the milestone against which your performance will be measured as you report actual persons served on the SAR during the contract period.

Type of Assistance Requested: Put an "X" in the box next to all that apply. You must choose either "Emergency Shelter" or "Transitional Housing."

Legislative Representative: Indicate the District Number, name, and mailing address for the Assembly and Senate Member for the project's location. To verify your legislative information go to www.leginfo.ca.gov or call the Chief Clerk at the Capitol at (916) 445-3614.

A. GENERAL APPLICANT INFORMATION—

To complete this section follow instructions on Pages 4 and 5.

STATE USE ONLY: Contract Number _____-EHAP-_____

Type of Information	**List Information below**
Applicant Name	
County allocation applied for	_____ County
Type of Applicant	☐ Nonprofit Corporation (501 [c][3]) **or** ☐ Government
Total Grant Amount Requested	$
City (project site)	
County (project site)	
(Administrative office) Street Address or P.O. Box City and Zip Code + **4 digits**	
Authorized Signatory Representative Name AND Title	☐Mr. ☐Ms. ☐Other_____
Telephone Number	
Fax Number	
Email Address	
Contact Person Name <u>AND</u> Title	☐Mr. ☐Ms. ☐Other_____
Telephone Number	
Fax Number	
Email Address	
Amounts Requested for Each Major Funding Category	
Acquisition	$
New Construction	$
Rehabilitation	$
Conversion	$
Equipment	$
Operations	$
Mortgage Payments	$
Lease/ Rent (circle one)	$
Residential Rental Assistance	$
Vouchers	$
Administration*	$
DLB Administration Fee**	$
TOTAL	$

*Administration <u>cannot</u> exceed 5% of the total grant amount. **For DLB Use Only. Use for passthrough grant.

To complete this page follow instructions on pages 4 and 5.

Primary Target Population: In the table below, check only one box next to the primary target population that will be served by this project. **DO NOT CHECK MORE THAN ONE BOX.**

1. ☐ Physically Disabled	8. ☐ Seniors
2. ☐ Persons with HIV/AIDS	9. ☐ Mentally Ill
3. ☐ Persons 24 years of age or younger	10. ☐ Veterans
4. ☐ Single Adults	11. ☐ Victims of Domestic Violence
5. ☐ Single Men	12. ☐ Substance Abusers
6. ☐ Single Women	13. ☐ Dually-Diagnosed
7. ☐ Families	14. ☐ General Homeless Population
	15. ☐ Other: _____

Project/Shelter: See Instructions on page 5. All sites must list physical address. Do not use P.O. Box.	County of site location	Requested Amount Per Site:	Avg. # Persons Served Daily (for all clients served)	Maximum Bed Capacity
Site 1 ☐ Confidential Site		$		
Site 2 ☐ Confidential Site		$		
Site 3 ☐ Confidential Site		$		
Site 4 ☐ Confidential Site		$		
		$ Total	Total	Total

Type of Assistance Requested: Insert "X" below:

Semi-Annual Report (SAR) Indicate the estimated number of unduplicated clients you anticipate serving over the 14 month grant period. (See pg. 5) _____	Emergency Shelter _____ Transitional Housing _____ Residential Rental Assistance _____ Vouchers _____

Legislative Representative:

Assembly District No.		Senate District No.	
Assembly Member Name and Address		Senate Member Name and Address	

B. STATEMENT OF APPLICANT ELIGIBILITY

Emergency Housing and Assistance Program
(EHAP)
Operating Facility Grant

The applicant, _____ hereby assures and certifies that it meets eligibility requirements as described in Title 25, Division 1, Chapter 7, Subchapter 12, Section 7950 and 7959 of the California Code of Regulations.

For Emergency Shelters and Transitional Housing, eligibility requires compliance with Section 7959(c) through Section 7959(f).

For Emergency Shelters only, eligibility requires that the shelter for which the EHAP funds are requested meets the definition of "Emergency shelter," found in Section 7950 and that it complies with Section 7950 Section 7959(g) through Section 7959 (j).

For Transitional Housing only, eligibility requires that the transitional housing program meets the definition of "Transitional housing," found in Section 7950 and that it complies with Section 7959(k) through 7959(l).

I certify that I have read and agree to adhere to the Regulations listed above in the operation of the Emergency Shelter and/or Transitional Housing facility for which EHAP funds are requested in this application.

CERTIFYING OFFICIAL: _____
(Print or Type)
Name of Person/Officer authorized in Resolution

_____
Signature Title

_____
Date

C. RATING AND RANKING CRITERIA

Please answer the following questions to describe your existing operations and demonstrate your capability to successfully complete the activities of your EHAP grant proposal. Be sure to include all information and requested supporting documentation. Insert all exhibits at end of Section I.

PROGRAM DESCRIPTION

Provide a brief description of the organization and program services it will offer with this requested grant (100 words or less).

1. APPLICANT CAPABILITY – 40 Points Maximum

a. **History of Providing Housing and Services to the Homeless**

1) How long has your organization offered client housing for the homeless?

_____ years _____ months

2) How long has your organization offered other (non-housing) services for the homeless?

_____ years _____ months

b. **Organizational Structure/Experience with Homeless Programs**

1) Provide your program's organizational chart. Clearly identify the chain of command and all levels of staffing. The organizational chart must include the job title/classification for all staff for which EHAP funds are being requested. These staff costs must be identified on the Detail of Operating Facility Grants (Exhibit J-3).

Label Organizational Chart "Exhibit A" and insert at end of Section I.

2) Complete the EHAP Project Key Staffing form and label "Exhibit B."

Do not include staff that may have contact with clients but don't provide "direct client services", such as: cooks, food handlers, security guards, etc.
All staff identified on the key staffing form must also be included on the organizational chart.

3) Provide duty statements for all key staff. Insert them immediately following "Exhibit B, Key Staffing chart." Label the duty statements "Exhibit B-1," Exhibit B-2," "Exhibit B-3," and so on depending on how many duty statements are included.

c. **Financial Management and Stability**

1) Describe the agency's financial management system (no more than half a page single spaced).

2) During the last five years, have you suspended services due to lack of funding? If yes, explain (100 words or less).

3) Attach the agency's most recent annual financial statement as "Exhibit C."
4) Attach the agency's most recent audit report as "Exhibit D" (Select no more than five pages from the report that includes findings/results of audit).
5) Attach the accountant's or financial manager's resume as "Exhibit E." If the position is vacant or does not exist, state so here.

d. **Demonstrated Ability, Readiness and Plan for Activities**

1) Provide a timeline and plan for implementing the proposed program upon receipt of EHAP funds (100 words or less).

2) Attach the Board Resolution as Attachment A in Section II. Follow the instructions and use the Sample Resolution. A correct Resolution is needed for contract execution.

2. IMPACT AND EFFECTIVENESS – 30 Points Maximum

a. Quality of Client Housing

1) What is the proposed ratio of clients to key staff? *

Number of Clients:_____ ÷ Number of key Staff:_____= ____ : 1
(Average No. of Persons Served Daily-Page 7) *(Total No. of key Staff – from Exhibit B, Total of Column C)*

2) SUPPORT SERVICES DETAIL
List all support services provided to clients as part of the program in which EHAP funds are being requested. For both Off-site and On-site services provided by an outside agency, attach letters from those agencies verifying the service listed in the first column. Label Exhibit F-1, F-2, F-3 and so on.

Type of Service and Description of Service	**Location**	**Agency Providing Off-site & On-site services**	**Exhibit Number**
EXAMPLE Job Counseling- includes resume prep, job readiness services, job search assistance, and brokering relationships with potential employers	☐ ***On-site or*** ☒ ***Off-site***	***Sacramento County EDD***	***Exhibit F-1***
	☐ On-site **or** ☐ Off-site		
	☐ On-site **or** ☐ Off-site		
	☐ On-site **or** ☐ Off-site		
	☐ On-site **or** ☐ Off-site		
	☐ On-site **or** ☐ Off-site		
	☐ On-site **or** ☐ Off-site		

b. **Activity Addresses Community Needs** (read Appendix A, Serving Selected Populations, before answering these questions).

1) What is your primary target population? Does the Continuum of Care Plan or other Homeless Plan identify the same target population as a priority? **(Attach applicable page from plan as "Exhibit G-1").** If not, what was the basis for selecting the target population?

2) What secondary groups do you serve? Are these groups a priority in the Continuum of Care, Local Emergency Shelter Strategy, or other Plan? **(Attach applicable page from plan as "Exhibit G-2").** If not, what was the basis for selecting the secondary target population(s)?

3) If your project meets a need identified as a priority in a county Continuum-of-Care or other plan, indicate the priority, i.e., high priority, medium priority or low priority, and identify any other needs that have an equal or higher priority. **(Attach applicable page from plan as "Exhibit G-3").**

c. Homeless Prevention

1) Explain the strategy you use to prevent homelessness. Discuss outreach efforts into the community to announce your homeless prevention services and steps that show early intervention in homelessness. (100 words or less)

2) Do you provide Residential Rental Assistance (RRA)?

_____ Yes _____ No

d. Demonstration of a self-supporting permanent housing environment for clients

(Programs will be compared against other programs of the same type.)

1. In the last 12 months, what number and percentage of clients who have exited your program have moved into permanent or transitional housing (overall placement rate)?

   Total number of clients who exited ____ Number placed _____ Percentage placed _____

2. For credit you must attach documentation to substantiate the placement rate. Examples of adequate documentation are copies of client outcome lists as submitted to the agencys Board of Directors, or copies of client lists with outcomes. Client confidentiality must be maintained. If the documentation does not clearly substantiate the information provided in the application, then the applicant will score zero on this question. Include as "**Exhibit H**" (limit to 3 pages).

3. COST EFFICIENCY – 30 Points Maximum

a. Cost Per Bed Calculation

Complete the following for each program/facility for which you are requesting EHAP funds. For the purposes of scoring this rating factor, only programs of the same housing type will be compared with one another.

When determining bed capacity (defined as the total number of beds and cribs regularly in use), cribs should be counted as beds.

Check one:

☐ **Emergency Shelter Facility**
☐ **Transitional Housing Facility**

Number of Beds: _____

Number of Cribs: +_____

Total Bed Capacity: =____

Projected Project Cost $_____
(Exhibit J-1, Income / Expense Statement , Total Expenses Column C)

$_____ ÷ _____ ÷ _____ = $_____

Projected Project Cost	Maximum Bed Capacity	14 Months	Bed Cost Per Month

Note: Household means one or more persons occupying a housing unit.

☐ **Voucher Program**
☐ **Residential Rental Assistance**

Total Number of households to be served for the grant period: _____
Average number of persons per household: _____

Projected Project Cost (Exhibit J-1, Income / Expense Statement , Total Expenses Column C) $_____

$_____ ÷ _____ ÷ _____ = $_____

Projected Project Cost	Total Households	14 Months	Household Cost Per Month

b. Availability of other Financial Resources

What has been the five-year history of your funding sources including EHAP funding? Include all types of funding. Start with the most recent year. Attach as "**Exhibit I**."

For example:

Year(s) received	Funding Source	$$ Received	If EHAP, contract no.
2005	Private	$10,000	
	EHAP	$30,000	05-EHAP-XXXX
	FEMA	$100,000	
2004	Private	$35,000	
2003	FESG	$50,000	
	Private	$10,000	
2002	CDBG	$5,000	
2001	CDBG	$5,000	

c. Need for EHAP Funds

Complete "**Exhibit J-1**, Income/Expense Statement," and "**Exhibit J-2**, Summary Budget and Fund Request."

d. Non-duplication of Services and Coordination with other organizations

In order to determine non-duplication of services for your program, ensure you complete chart on page 11, Support Services Detail. The letters requested for documentation of the Support Services detail will be considered for this rating criterion.

Included in our application are: ☐ 3 letters ☐ 2 letters ☐ 1 letter ☐ No letters

State of California—Department of Health Services

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 6-2003)

1

INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this **fully completed** form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.
NOTE: Governmental entities, federal, state, and local (including school districts), are not required to submit this form.

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)	
SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS
MAILING ADDRESS	BUSINESS ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): ☐☐ — ☐☐☐☐☐☐☐

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION:

☐ **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)
☐ **LEGAL** (e.g., attorney services)
☐ **EXEMPT** (nonprofit)
☐ **ALL OTHERS**

☐ **INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:** ☐☐☐ — ☐☐ — ☐☐☐☐

(SSN required by authority of California Revenue and Tax Code Section 18646)

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4

PAYEE RESIDENCY TYPE

☐ California resident—qualified to do business in California or maintains a permanent place of business in California.

☐ California nonresident (see reverse side)—Payments to nonresidents for services may be subject to State income tax withholding.

- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)	TITLE	
SIGNATURE	DATE	TELEPHONE ( )

6

Please return completed form to:

Department/Office: Department of Housing and Community Development

Unit/Section: Division of Financial Assistance

Mailing Address: 1800 3rd Street - 390-4

City/State/ZIP: Sacramento, CA 95814

Telephone: (916) 322-6092 **FAX:** (916) 323-6016

E-Mail Address: SPorter@hcd.ca.gov

1	**Requirement to Complete Payee Data Record, STD. 204** A completed Payee Data Record, STD. 204, is required for payments to all non-governmental entities and will be kept on file at each State agency. Since each State agency with which you do business must have a separate STD. 204 on file, it is possible for a payee to receive this form from various State agencies. Payees who do not wish to complete the STD. 204 may elect to not do business with the State. If the payee does not complete the STD. 204 and the required payee data is not otherwise provided, payment may be reduced for federal backup withholding and nonresident State income tax withholding. Amounts reported on Information Returns (1099) are in accordance with the Internal Revenue Code and the California Revenue and Taxation Code.
2	Enter the payee's legal business name. Sole proprietorships must also include the owner's full name. An individual must list his/her full name. The mailing address should be the address at which the payee chooses to receive correspondence. Do not enter payment address or lock box information here.
3	Check the box that corresponds to the payee business type. Check only one box. Corporations must check the box that identifies the type of corporation. The State of California requires that all parties entering into business transactions that may lead to payment(s) from the State provide their Taxpayer Identification Number (TIN). The TIN is required by the California Revenue and Taxation Code Section 18646 to facilitate tax compliance enforcement activities and the preparation of Form 1099 and other information returns as required by the Internal Revenue Code Section 6109(a). The TIN for individuals and sole proprietorships is the Social Security Number (SSN). Only partnerships, estates, trusts, and corporations will enter their Federal Employer Identification Number (FEIN).
4	Are you a California resident or nonresident? A corporation will be defined as a "resident" if it has a permanent place of business in California or is qualified through the Secretary of State to do business in California. A partnership is considered a resident partnership if it has a permanent place of business in California. An estate is a resident if the decedent was a California resident at time of death. A trust is a resident if at least one trustee is a California resident. For individuals and sole proprietors, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose that will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident. Payments to all nonresidents may be subject to withholding. Nonresident payees performing services in California or receiving rent, lease, or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for State income taxes. However, no withholding is required if total payments to the payee are $1,500 or less for the calendar year. For information on Nonresident Withholding, contact the Franchise Tax Board at the numbers listed below: Withholding Services and Compliance Section: 1-888-792-4900 E-mail address: wscs.gen@ftb.ca.gov For hearing impaired with TDD, call: 1-800-822-6268 Website: www.ftb.ca.gov
5	Provide the name, title, signature, and telephone number of the individual completing this form. Provide the date the form was completed.
6	This section must be completed by the State agency requesting the STD. 204.

Privacy Statement

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency, which requests an individual to disclose their social security account number, shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

It is mandatory to furnish the information requested. Federal law requires that payment for which the requested information is not provided is subject to federal backup withholding and State law imposes noncompliance penalties of up to $20,000.

You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the State agency(ies) with which you transact that business.

All questions should be referred to the requesting State agency listed on the bottom front of this form.

EXHIBIT A

ORGANIZATION CHART

Note: For applications covering more than one Shelter Facility or Program, copy this page as many times as necessary and complete a separate sheet for each.

Applicant/Organization: _____ Project Name: _____Project Address:_____

EHAP PROJECT KEY STAFFING

DEFINITION of "Key Staff"
Key staff consists of the organization's staff and volunteers that provide "direct client services" for the project for which EHAP funds are being requested.

Do not include staff that may have contact with clients but don't provide "direct client services", such as: cooks, food handlers, security guards, etc.

List all current and proposed key staff positions, (EHAP funded, non-EHAP-funded and Volunteers). See sample entry for "Intake Worker" position.
Attach directly behind this page copies of duty statements for each key staff position. The duty statement must clearly indicate the direct client services provided by the key staff. Copy this page as necessary.

Current Program **Past Related Work Experience**

	A	B	C	D	E		F	G
Position Title	Degree, Education and/or Licenses	Staff Name (If vacant or proposed so state)	FTE %*	Years in This Position	Total years (CxD)	Position Title of past experience **(In releated field only)**	Total years	Grand Total Years Worked (E+F)
Intake Worker	H.S.	Haley Mills	.5	5	2.5	Shelter Aide	3	5.5
Total Number of Key Staff Equivalent						Total Number of Years		

*Full Time Equivalent (FTE)=160 hours per month.

% Example: 80 hrs. ÷ 160 hrs.=.5 FTE

EXHIBIT B-1
EXHIBIT B-2
EXHIBIT B-3
AND SO ON

DUTY STATEMENTS

EXHIBIT C

ANNUAL FINANCIAL STATEMENT

EXHIBIT D

AUDIT REPORT

EXHIBIT E

FINANCIAL MANAGER'S RESUME

EXHIBIT F-1
EXHIBIT F-2
EXHIBIT F-3

SUPPORT SERVICES LETTERS

EXHIBIT G-1
EXHIBIT G-2
EXHIBIT G-3

CONTINUUM OF CARE PLAN OR OTHER PLAN SHOWING COMMUNITY NEEDS

DOCUMENTATION OF CLIENT PLACEMENT INTO TRANSITIONAL HOUSING OR PERMANENT HOUSING

EXHIBIT I

FIVE YEAR HISTORY OF FUNDING SOURCES

Applicant _____ Site/Project _____ **EXHIBIT J-1**

INCOME AND EXPENSE STATEMENT: All applicants must complete columns B and C for your program.

(A) **INCOME**	(B) **CURRENT Fiscal Year** 07/06 – 06/07	(C) **PROJECTED Fiscal Year** 07/07–06/08
Private Donations		
Local Govt._____		
State – EHAP Column B- enter current EHAP 13 grant amount (if funded). Column C- enter the EHAP 14 grant request amount.		
State –Other _____		
FEMA		
CDBG		
Federal – Other _____		
Rental Income		
Fees		
Other_____		
Other_____		
TOTAL INCOME	$	$
EXPENSES		
Acquisition		
New construction		
Rehabilitation		
Conversion		
Equipment		
Administration		
Operations		
Mortgage Payments		
Lease/Rent		
Residential Rental Assistance		
Vouchers		
Other_____		
Other_____		
TOTAL EXPENSES	$	$

Accountant/Auditor Name _____ Telephone Number _____

EXHIBIT J-2

SUMMARY BUDGET AND FUND REQUEST – Operating Facility Grants:

Summarize the total projected project costs (expenses) and EHAP grant request below.

Operating Facility grants may include $20,000 or less in capital development-type expenditures (lines 1 through 5).

The total EHAP grant request must not exceed $100,000 or the county allocation, whichever is less.
Not more than 5% of the total grant amount can be used for administration.
Be sure only eligible costs are charged to EHAP.

A	B	C
ACTIVITY	TOTAL PROJECTED PROJECT COST (EXPENSES)	EHAP GRANT REQUEST
1. Acquisition	$	$
2. New construction		
3. Rehabilitation		
4. Conversion		
5. Equipment		
SUBTOTAL (lines 1-5)	$	$
6. Administration		
7. Operations		*
8. Mortgage Payments		
9. Lease/Rent		
10. Residential Rental Assistance (RRA)		
11. Vouchers		
12. Other _____		
13. Other _____		
GRAND TOTAL (1-13)	$**	$***

* TOTAL from Detail of Operating Facility Grants (Exhibit J-3) .

** Total Expenses, from Column C of Income and Expense Statement (Exhibit J-1).

*** State – EHAP, from Column C of Income and Expense Statement (Exhibit J-1)

Applicant _____ Site/Project _____

DETAIL OF OPERATIONS ACTIVITIES

Detail of Operations Activities	EHAP Grant Requested Amount	Job titles and percentage to be charged to EHAP grant. (List each job title and the EHAP percentage separately)
Staff providing services directly to clients (including payroll taxes)	$	
Counseling clients and supervising the counseling services (including payroll taxes)	$	
		Note: Provide a clear explanation of what activities the EHAP funds will pay for and show the calculations; or attach an explanation and mark " See Attachment" in the space below.
Utilities (list each utility separately)	$	
Office supplies, document duplication, printing, and mailing	$	
Routine maintenance and repairs	$	
Taxes and Insurance (for the housing site)	$	
Other (please specify) *	$	*Do not include Administration funds in “Other.” Administration is a separate activity.
TOTAL	$	Total must equal Operations total from Exhibit J-2, line 7, column C.

Expenses involving food and transportation are NOT eligible under the EHAP regulations.

Please see EHAP Regulation 7962 for a listing of other ineligible activities. Contact the EHAP Staff if you have any questions regarding the eligibility of an expense for EHAP funding.

SECTION II

SAMPLE RESOLUTION INSTRUCTIONS/CHECKLIST

The Resolution accompanying an application for the Emergency Housing and Assistance Program (EHAP) must include the information contained in the Sample Resolution. Please confirm the following requirements have been met:

- The Sample Resolution language and format (see Sample Resolution next page) has been used and retyped on your organization's letterhead (**Do not use the Sample Resolution page**).

- The name of the applicant organization that is listed on the Resolution must match the organization name that appears on the Articles of Incorporation filed with the Secretary of State. Be consistent throughout the Resolution to use the exact name. **Do not include DBAs or names of project sites or programs.**

- The Resolution shows the date of the board action to approve the Resolution. For organizations in Non-Designated Local Board (DLB) counties this board action must occur **after September 22, 2006 and on or before November 16, 2006.** For organizations in DLB counties, the Resolution must be executed after the date the DLB's Regional NOFA was issued and before the DLB's application deadline.

- The title/officer of the person authorized to sign the Standard Agreement (and not the specific person's name) was included.

- The vote tally section has been fully completed, including noting the number of Ayes, Noes, Abstentions and Absentees.

- The Approving Officer, who signs the Resolution, cannot be the Authorized Officer named to sign the EHAP Application and the EHAP Standard Agreement.

- The "Approving Officer" and the "Attest" lines have been signed and the required titles/names have been printed below the signatures.

- The Department will accept the following Board of Director's officers signatures as "Approving Officer" for the EHAP Resolution: Board Chair, Board President, Board Vice-President, or Board Secretary. The Board Treasurer cannot sign as the "Approving Officer" unless a separate Resolution exists to allow the Treasurer to sign the EHAP Resolution.

Please make sure the Resolution has been prepared using the Sample Resolution format. In past years, approximately 25% of the Resolutions contained errors or omissions. Following up with grantees to obtain corrected Resolutions is extremely time consuming and causes delays in executing Standard Agreements.

SAMPLE RESOLUTION -- Always submit on Applicant letterhead

RESOLUTION
WHEREAS:

A. WHEREAS, the State of California, Department of Housing and Community Development, Division of Financial Assistance, issued a Notice of Funding Availability (NOFA) for the Emergency Housing and Assistance Program (EHAP) (Round EHAP 14); and

B. [_____] is a nonprofit corporation or local
(Insert Name of Application Organization)
government agency that is eligible and wishes to apply for and receive an EHAP grant;

NOW THEREFORE BE IT RESOLVED THAT:

1. The Board of Directors of [_____] hereby authorizes
(Insert Name of Applicant Organization)
[_____] to apply for an EHAP grant in an amount not more than the
(Insert Title of Authorized Person/Officer)
maximum amount permitted by the NOFA, and in accordance with the program statute, Regulations, and Local Emergency Shelter Strategy, where applicable.

2. If the grant application authorized by this Resolution is approved, the [_____]
(Insert Name of Applicant Organization)
hereby agrees to use the EHAP funds for eligible activities in the manner presented in the application as approved by the Department and in accordance with the program statute (Health and Safety Code Section 50800 – 50806.5) and Regulations (Title 25, Division 1, Chapter 7, Subchapter 12, Sections 7950 through 7976 of the California Code of Regulations); (Chapter 47, Statutes of 2006), and the Standard Agreement.

3. If the grant application authorized by this Resolution is approved, [_____]
(Insert Title of Authorized Person/Officer)
is authorized to sign the Standard Agreement and any subsequent amendments with the Department for the purposes of this grant. **(**Remember to use only the **title** of the person in case of staff/board turnover. Delays caused by naming individuals may jeopardize your grant.)

PASSED AND ADOPTED at a regular meeting of the [_____]
(Insert Name of Applicant Organization)
this ____ day of _____, 200__ by the following vote:

AYES: _____ ABSTENTIONS: _____

NOES: _____ ABSENT: _____

_____
Signature of Approving Officer

_____
Printed Name and **Title** of Approving Officer

ATTEST: _____
Signature and **Title**

Policies and Conditions of Stay

Copy of IRS Form 501 (c) (3)

Articles of Incorporation and any amendments

Evidence of Site Control

SECTION III

SECTION III:

Applicant _____ Site/Project _____

ADDITIONAL GRANT PROPOSAL INFORMATION FOR OPERATING FACILITIES WITH CAPITAL DEVELOPMENT-TYPE ACTIVITIES (i.e. Acquisition, New Construction, Rehabilitation, Conversion, or Equipment)

A. SITE DESCRIPTION: Copy this page as needed if project involves scattered sites to prepare a separate summary for each site. Attach additional pages as needed to answer the questions.

1. Is the site currently owned or leased (circle one) by applicant? ____ Yes ____ No
   If yes, since when? ____/____/____If lease, give term:____/____/____ to ____/____/____
   If not owned, give name and address of current legal owner and describe how title is held:

2. If site acquisition is proposed, briefly describe the timeframe, financing, and any unusual issues:

3. Legal property description:

4. Land use description:

   Current Zoning Designation: _____

   Current General Plan Designation: _____
   Do current zoning and general plan designations permit use for

   emergency shelter or transitional housing? _____ Yes _____ No

   If no, how will the proposed facility be accommodated, and when? ____/____/____
   [ ] Rezoning [ ] General Plan amendment
   [ ] Zoning Variance [ ] Conditional Use Permit
   [ ] Other_____

5. Has the Certificate of Occupancy been issued? _____ Yes _____ No

   If yes, give date ____/____/____, and ____ number of persons and provide a copy of the Certificate of Occupancy (Mark the Certificate of Occupancy as A.5.).

6. Lot Size: _____ Sq. Ft. or _____ acres

7. Building Information: ____ Existing ____ Proposed (check one, and briefly describe number, type, and square footage of the buildings)

Total Number of:

Rooms	_____	Bedrooms	_____
Beds/Spaces	_____	Kitchen(s)	_____
Bathroom(s)	_____	Office	_____
Dining	_____	Recreation/Living	_____

Other: _____

B. PROJECT ACTIVITIES SCHEDULE:

Show the schedule of the steps required to complete the capital development activities including the expected dates when each step will be accomplished. Include such steps, as applicable, as preparing the plot map, obtaining local planning and building department approvals, preparing bid packages, executing construction contracts, starting and completing construction, and closing escrow.

Applicant _____ Site_____

C. DETAILED COST ESTIMATES FOR OPERATING FACILITIES WITH CAPITAL DEVELOPMENT ACTIVITIES: Copy additional pages, as needed.

Estimator's Name: _____ Profession: _____

Estimator's Signature: _____ License: _____

Summarize the work or equipment items by activity (e.g., rehabilitation, conversion). Figures here should be carried forward to the Summary Budget and Fund Request. Note that after the grant award, competitive bidding is required to determine building contractor(s) and/or major equipment supplier(s).

A	B
Work or Equipment Item - Include quantity and unit cost, or hours and hour cost	Total Cost

APPENDIX A

SERVING SELECTED POPULATIONS WITH EHAP FUNDING

Serving Selected Populations With EHAP Funding
October 2003

The following is a simplified layman's guide for shelter providers seeking to serve selected populations using Emergency Housing and Assistance Program (EHAP) funds administered by this department.

Legal Requirements:

Generally, service to selected populations must comply with a variety of legal requirements, including the 14th Amendment to the U. S. Constitution, the U. S. Fair Housing Act (and amendments) of 1968 (and 1988), the California Fair Employment and Housing Act and the California Unruh Civil Rights Act. Depending on the circumstances, other statutes may apply, including Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Additionally, there are specific applicable provisions of the EHAP Statutes (Health and Safety Code Section 50800, et seq.) Given the potential overlap of legal requirements, shelter providers should consult an attorney to identify the specific applicable requirements for serving any selected population of clients.

EHAP Emergency Shelter "First-Come, First-Served" Requirements:

Emergency shelter facilities receiving funds from EHAP are required (See H&S Section 50801.5(b).) to provide emergency shelter and services *"…on a first-come, first served basis for whatever time periods are established for the shelter."* HCD believes that this provision prohibits the use of EHAP funds for emergency shelters for selected populations. However, recognizing that many shelter providers have mission-driven restrictions, HCD has allowed the funding of such shelters provided that no homeless individual or family is forced to remain without shelter while there is available bed space. In such circumstances where any client is denied shelter when there is a vacancy, EHAP emergency shelter providers must ensure that there is adequate alternate accommodation - including referral arranging for a bed or providing a voucher for a bed at an alternate facility and reasonable transportation to that facility.– to any client denied shelter when there is a vacancy.

EHAP Transitional Housing:

Transitional housing facilities receiving funds from EHAP are not subject to the first come, first-served provisions for like emergency shelter facilities, but they are still subject to other legal requirements affecting client service. Among those requirements are EHAP regulations (Section 7959 (e)), which, as an eligibility requirement, prohibit EHAP applicants or grantees from providing client housing in a manner that denies benefits on an arbitrary basis, and case law for the Unruh Civil Rights Act, which prohibits all arbitrary discrimination. Under Unruh, discrimination is considered non-arbitrary if the nature of the physical facilities or the nature of the services provided reasonably necessitates a particular restriction. Because whether a transitional housing provider is in compliance with Unruh is a fact driven question, applicants and contractors are encouraged to consult their own legal counsel regarding this issue.

If a State or Federal law or regulation requires an EHAP transitional housing facility to exclusively serve a select homeless subpopulation, such a restriction would not be considered arbitrary.

Stewart B. McKinney Homeless Assistance Act (McKinney Act) Compatibility:

H&S Section 50800 (c) allows EHAP funds to be used in emergency shelter facilities receiving funds from McKinney Act Programs which require exclusive services to selected populations – provided that the McKinney Act client restrictions arise in the McKinney Programrequirements law or regulations (as opposed to restrictions arising from those self-imposed by the applicant/shelter provider.) Contracts between the shelter provider and HUD that merely codify client restrictions proposed by McKinney Act recipients are insufficient basis for invoking the McKinney Act exemption to the EHAP first-come, first-served requirements.

Selecting Clients on the Basis of Sex:

H&S Section 50801.5 (b) effectively allows emergency shelter and transitional housing providers using EHAP funds to restrict occupancy on the basis of sex – provided that the restrictions are not arbitrary. Generally, that means that in EHAP funded facilities, notwithstanding the Unruh Civil Rights Acts or any other provision of law, shelter and services may be offered exclusively for either women or men – provided that any such exclusivity is based on a reasonable service need.

Selecting Clients on the Basis of Age

H&S Section 50801.5 (b) also permits emergency shelter and transitional housing providers to restrict occupancy exclusively to persons 24 years of age or younger. Generally, that means that in EHAP-funded facilities, notwithstanding the Unruh Civil Rights Act or any other provision of law, shelter and services may be offered exclusively to persons 24 years of age or younger – provided that any such exclusivity is based on a reasonable service need.

Serving Clients on the Basis of Military Veteran Status

H&S Section 50801.5(b) also permits emergency shelter and transitional housing providers to restrict occupancy exclusively to military veterans if the veterans served possess significant barriers to social reintegration and employment due to a physical or mental disability, substance abuse, or the effects of long-term homelessness that require specialized treatment and services and the provider of emergency shelter or transitional housing also provides the specialized treatment and services.

Generally, that means that in EHAP funded facilities, notwithstanding the Unruh Civil Rights Act or any other provision of law, shelter and services may be offered exclusively to military veterans, provided that any such exclusivity is based only on the criteria set forth in H&S Section 50801.5 (b). Furthermore, emergency or transitional housing providers with facilities that serve military veterans exclusively must demonstrate that there is a reasonable relationship between the specialized treatment and services offered to military veterans and the population restriction itself.

Selecting Clients on the Basis of Family Status:

With respect to using EHAP funds for shelter and services exclusively for either women or men (as allowed under H&S Section 50801.5(b) indicated above) there are limits to the restrictions that can be imposed when serving families. In the case of families, providers of emergency shelter or transitional housing which operate single sex facilities shall provide, to the greatest extent feasible, adequate facilities within their range of services so that all members of a family may be housed together, regardless of age and gender. In other words, families should not be forced to split up in order to stay in EHAP funded facilities that would otherwise exclusively serve either men or women.

If there are any questions regarding these issues, please contact the HCD Homeless Programs at (916) 445-0845.